Cancer, Specified Disease and Intensive Care Coverage

Underwritten by: Manhattan Life Insurance Company
Administered by: Bay Bridge Administrators LLC

Claim Filing Instructions

How to file your first claim:

1. Complete each section of the first page of the claim form.
2. Attach a copy of the **pathology report(s)** with a **positive diagnosis** of cancer or a specified disease. Be sure to attach the earliest diagnosis of cancer or specified disease to ensure proper payment of benefits.
3. **For Intensive Care Coverage claims only – please complete each section of the first page of the claim form and attach a copy of the itemized bill from your hospital stating dates you were billed for intensive care confinement and the diagnosis codes for the confinement**.

Itemized medical bills/statements & corresponding health insurance explanation of benefit statements (EOB's):

Please obtain itemized medical bills from your medical providers. The medical bills need to include the provider name, address and telephone number, date of service, list of all procedures billed, amount billed and corresponding diagnosis code(s). We are unable to process benefits from account summary/balance statements. **Please also include copies of all health insurance explanation of benefit statements which correspond with your itemized medical bills. A copy of your health insurance explanation of benefit statement is needed to process all benefits of the policy which provide for payment of benefits that state "actual charge(s)".**

Deadline to submit losses/expenses:

All proofs of loss must be received in our office within 15 months from date incurred.

Submitting Additional Claims:

The Insured does not need to fill out a claim form each time. On a cover sheet or posted note, please write the Insured's name and claim number. Attach it to the first page of the medical bill:
Example: **John Smith - Claim No:**
Attn: Cancer Claim

Questions

If you have questions or need assistance, please call us toll free at 1-800-845-7519 and ask to speak with a Claims Examiner about your cancer and specified disease policy Monday – Friday, 8:00AM-5:00PM, (CST) Central Standard Time.

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECCESARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.

Return fully completed claim form and supporting documentation via:

Online Portal	Email	Mail	Fax
portal.bbadmin.com	claims@bbadmin.com	Bay Bridge Administrators, LLC PO Box 161690 Austin TX 78716	512-275-9350

For questions call: 800-845-7519

Claim Form for **Cancer, Specified Disease** and **Intensive Care** Coverage *no claim form required if filing for wellness benefit only*	**Underwritten by: Manhattan Life Insurance Company** **Administered by: Bay Bridge Administrators, LLC** **PO Box 161690** **Austin TX 78716**

INSURED'S STATEMENT OF CLAIM

Name of Insured:	Insured's Date of Birth:	Policy Number:
Street Address:		Phone Number (area code first):
Name of Claimant:	Claimant's Date of Birth:	Relationship to Insured:

Type of Illness for which claim is being made:	Date of first diagnosis:	Date you were first treated for your Illness:

Describe the onset and nature of your Illness:

_____

_____

_____

_____

_____

_____

Have you ever had the same or a similar condition in the past? ☐ Yes ☐ No Date _____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address
Have you ever had the same or a similar condition in the past? ☐ Yes ☐ No Date _____	_____ Treated by: Hospital: _____ Name Address Doctor: _____ Name Address

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The above Statements are true to the best of my knowledge and belief.

_____ _____

Signature of Insured **Date**

AUTHORIZATION

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that my protected health information will be used for the purpose of evaluating my claim. I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this authorization.

2. I authorize all health care professionals, pharmacies and pharmacy benefit managers to disclose my protected health information.

3. I authorize only designated staff of Bay Bridge Administrators, L.L.C. to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Bay Bridge Administrators, L.L.C. This revocation shall become effective on the date it is received by Bay Bridge Administrators, L.L.C. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

6. This Authorization is valid for twelve (12) months from the date of execution hereof.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

Signature	Print Name	Date

I have legal authority* under the laws of the State of _____ to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

Name of Authorized Representative Parent or Guardian	Relationship to Applicant	Date

*A copy of the legal authority document must be on file with Bay Bridge Administrators, LLC

If claim is being filed during the first two years of the policy, please complete the following and sign and date the authorization on the preceding page.

Please list all physicians that treated the patient in the last 2 years:

Physician's Name:

Address:

Telephone Number: ____________________ Fax Number: ____________________

Approximate Date Consulted: ________________ Diagnosis: ____________________

Physician's Name:

Address:

Telephone Number: ____________________ Fax Number: ____________________

Approximate Date Consulted: ________________ Diagnosis: ____________________

Physician's Name:

Address:

Telephone Number: ____________________ Fax Number: ____________________

Approximate Date Consulted: ________________ Diagnosis: ____________________

Physician's Name:

Address:

Telephone Number: ____________________ Fax Number: ____________________

Approximate Date Consulted: ________________ Diagnosis: ____________________

Insured:_____ **Claimant:**_____ **Date:**_____

Please list all prescribed medications now being taken by patient:

Name of Medication	Prescribing Doctor	Date First Prescribed

Return fully completed claim form and supporting documentation via:

Online Portal:
portal.bbadmin.com

Email:
claims@bbadmin.com

Mail:
Bay Bridge Administrators, L.L.C.
PO Box 161690
Austin TX 78716

Fax:
512-275-9350

For questions call: 800-845-7519

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to prosecution and punishment for insurance fraud.

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECCESARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.

FRAUD WARNING

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

BAY BRIDGE ADMINISTRATORS

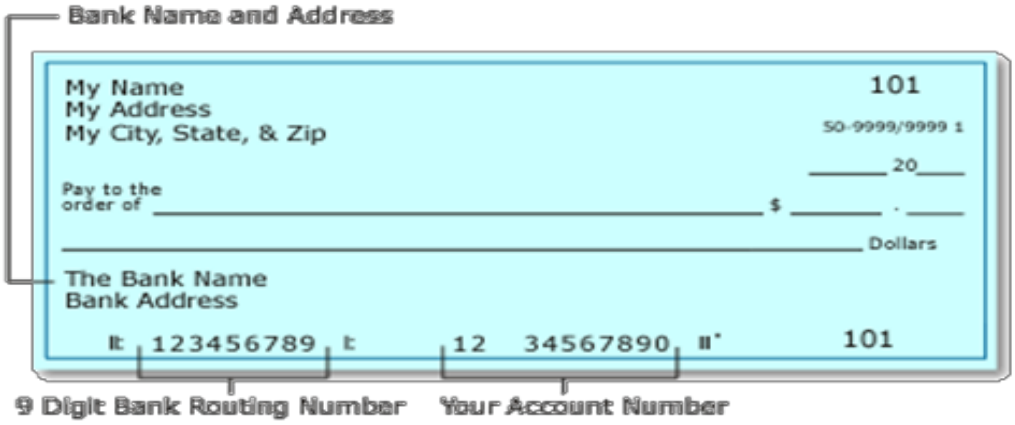
We are pleased to offer electronic ACH (Automated Clearing House) payments for your supplemental coverage benefit payments. ACH payments provide an alternative to paper checks, affording you the following advantages:

- Better cash management forecasting - accelerated funds availability – certainty of delivery
- Establishment of excellent payment and credit records
- Being part of "Going Green" by reducing paper

Enroll now and enjoy the convenience of direct deposit—no more waiting on paper checks or dealing with mail delays. Payments go straight to your bank account! You'll still receive your Explanation of Benefits (EOB) by mail, but why not take it a step further? Sign up for our Online Portal and access your EOBs anytime, anywhere. It's fast, secure, and easy to use. Activate your account now at portal.bbadmin.com and make the switch to a smoother, paperless experience!

Frequently Asked Questions

How do I get started? Complete and sign the Direct Deposit Authorization Agreement Form. Below reflects where you find the bank routing/bank account numbers that need to be included.



What is the process of enrolling in ACH? Once we receive your completed form, the form is sent to the team that builds the ACH set up.

How long does the ACH enrollment process take? It could take up to 3 business days for the ACH to become effective.

What needs to happen if we change account numbers or financial institutions? If you want to change your ACH electronic authorization, please complete another Direct Deposit Authorization Agreement Form and submit it. Include a note on the form indicating this is for a change in information.

How long does the ACH authorization remain in effect? Your authorization will remain in effect until we receive notification form you that you prefer receiving a check in the mail.

Indemnity Policy Benefit Payment - Direct Deposit Authorization Agreement

First Name _____ MI _____ Last Name _____ SSN _____

Street Address _____ City _____ State _____ ZIP Code _____

Phone _____ Email _____

Bank Name _____ Account # _____ Routing/Transit No _____ Account Type: ☐ Checking ☐ Savings

Bank Address: Street, City, State, Zip _____ Name(s) on Bank Account _____

Please Attach Voided Check Here

☐ I (we) hereby authorize Bay Bridge Administrators, LLC hereinafter call "Company" to initiate credit entries to my (our) account indicated above at the depository financial institution named above, hereinafter called "Bank," and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.
This authorization is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Bank a reasonable opportunity to act on it.

Authorized Signature _____ Date _____
(Signature must match signature card on account)

☐ Electronic Communications Policy *Go Paperless Today!*
By accessing and using the Bay Bridge Administrators, LLC portal, you agree to receive electronic communications from us regarding your insurance policies and claims. Such electronic communications may include but are not limited to policy documents, claims correspondence, and notices. We may send these communications to you by email, text message, or other electronic means, and we may use automated technology to communicate with you.
By agreeing to receive electronic communications from us, you acknowledge and agree that: You have the necessary equipment, software, and internet connection to receive and access these communications. Your electronic acceptance of any communication is legally binding and has the same effect as a physical signature. You may withdraw your consent to receive electronic communications at any time by contacting us using the information provided on our website. However, withdrawing your consent may limit our ability to provide you with certain services. We may send you promotional or marketing messages as part of our electronic communications. You may opt-out of receiving such messages at any time. Please note that certain states require us to obtain your consent to receive electronic communications related to your insurance policies and claims.
By accepting this policy, you confirm that you have read and understood the terms of this Electronic Communications Policy and consent to receive electronic communications from us as described above. By signing electronically, I agree that my electronic signature is the legal equivalent of my manual/ handwritten signature. ***Activate your portal registration at portal.bbadmin.com.***

Authorized Signature _____ Date _____

Bay Bridge Administrators, LLC.
P.O. Box 161690, Austin, TX 78716
Phone: (800) 845-7519 Fax: (512) 275-9350
Email: Underwriting Team: underwriting@bbadmin.com
Website: www.bbadmin.com ***Portal***: portal.bbadmin.com

BAY BRIDGE ADMINISTRATORS